

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$12,694.90 for date of service, 08/29/01.
- b. The request was received on 08/22/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. UB-92 (s)
 - c. EOB/TWCC 62 forms/Medical Audit summary
 - d. Medical Records
 - e. Managed HealthCare Agreement
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. Carrier Methodology
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/20/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/20/02. The response from the insurance carrier was received in the Division on 09/27/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 09/16/02

“The Carrier provided individual payment exception codes of ‘M’ for *each* line item of billed charges. However, several of the billed charges had a maximum allowable reimbursement per the TWCC Fee Guidelines and were not reimbursed by the Carrier for the ‘MAR’ amounts. Further the Carrier has inconsistently reimbursed for billed charges with a corresponding ‘MAR.’ Specifically, the enclosed EOB’s evidence that the Carrier does reimburse per the TWCC Fee Guideline for billed charges, which have a ‘MAR,’ but the Carrier has not done so in this instance. Therefore, the Carrier’s application of ‘M’ for each billed item is not in accordance with the Texas Administrative Code and the Commission’s instructions and the **requestor is entitled, at the minimum, to the fee guideline reimbursement amount for billed items which have a ‘MAR’ per the TWCC Fee Guideline....** In this instance, the Carrier did not provide any documentation of a developed or consistently applied methodology, which was used in reducing payment for the treatment/service in question. In addition, it appears the reduction taken by the Carrier has not been applied consistently....”

2. Respondent: Letter dated 09/26/02

“...(Carrier’s) payment is consistent with the fair and reasonable criteria established in Section 413.011 (b) of the Texas Labor Code. (Carrier) used data from two national resources: 1) ASC charges as listed by CPT code in ‘1994 ASC Medicare Payment Rate Survey.’ and 2) ASC Group payment rates as determined by the Secretary of the U.S. Department of Health and Human Services for surgical procedures by CPT code. (Carrier) used this data in the following manner: 1) The payment rate for the service in dispute, as defined by the CPT code, is determined using Medicare’s ASC Group rates. 2) The median charge from ASCs, weighted by total volume, is determined for the service group. 3) The co-payment amount is determined by multiplying the median weighted facility charge by 20%. 4) The dollar amounts from B.1) and B.3) above are summed to determine the fair and reasonable payment for the service... For these reasons (Carrier) believes it has made a fair and reasonable payment for the services provided....”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/29/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor’s Table of Disputed Services, the Requestor billed the Carrier \$13,978.02 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$922.00 for services rendered on the date of service in dispute above.
5. The Carrier's EOBs denied any additional reimbursement as "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)." and "OPSR M – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM".
6. Per the Requestor's Table of Disputed Services, the amount in dispute is \$12,694.90 for services rendered on the date of service in dispute above.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The Provider has submitted a copy of a managed care contract indicating payment of 70% was expected. The carrier has submitted documentation and an explanation of their methodology to justify they have paid a fair and reasonable reimbursement.

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". The carrier asserts that EOBs do not constitute a pattern substantiating fair and reasonable.

The Respondent indicates that the following data was used to determine their fair and reasonable reimbursement: 1) The payment rate for the service in dispute, as defined by the CPT code, is

determined using Medicare's ASC Group rates. 2) The median charge from ASCs, weighted by total volume, is determined for the service group. 3) The co-payment amount is determined by multiplying the median weighted facility charge by 20%. 4) The dollar amounts from B.1) and B.3) above are summed to determine fair and reasonable payment for the service.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of what is fair and reasonable. As the requestor, the health care provider must supply documentation that "...discusses, demonstrates, and justifies that the payment being sought is a fair and reasonable rate of reimbursement..." pursuant to TWCC Rule 133.307 (3) (g) (D). The Provider only submitted a copy of a managed care contract indicating payment of 70% was expected. However, that contract is 10 years old. It does not provide current information. The Provider has not provided sufficient information that supports its fees billed are fair and reasonable. Respondent has provided their methodology, which conforms to the additional criteria of Sec. 413.011 (d).

The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. In this case, the Requestor has failed to support their position that the amount billed is fair and reasonable and the Respondent has submitted enough information to support the argument that the amount reimbursed represents a fair and reasonable reimbursement. Therefore, **no additional** reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D) and (j) (1) (F).

The above Findings and Decision are hereby issued this 17th day of April 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt